Never Events List 2015-16

DRAFT FOR CONSULTATION
# Draft revised Never Events Policy Framework for consultation

## Document Purpose
Consultations

## Document Name
Draft revised Never Events Policy Framework for consultation

## Author
NHS England/Patient Safety Domain

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06 October 2014

## Target Audience
CCG Clinical Leads, CCG Accountable Officers, Medical Directors, Directors of Nursing, NHS England Area Directors, GPs

**Description**
A core team of patient safety experts and health professionals have produced the initial draft of the revised framework, including professional organisations and NHS England staff in regional and area offices. Feedback received in consultation on the Standard Contract was also used to update sections of the policy. We are now seeking wider views and opinions on the proposed changes via the public consultation. The consultation closes on 31 October 2014. Responses will then be analysed and we will aim to publish the final revised Never Events Policy Framework by the end of the year, along with a summary of the consultation’s findings.

## Cross Reference
The never events policy framework

## Superseded Docs (if applicable)

## Action Required
Review and feedback.

## Timing / Deadlines (if applicable)
By 31 October 2014

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## Document Status
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# The never events list

The following never events list is the list that all organisations providing NHS care should work from.

This is the revised list and definitions for use in the NHS from XXXX

## SURGICAL

### 1. Wrong site surgery

A surgical intervention performed on the wrong patient or wrong site (for example wrong knee, wrong eye, wrong limb, or wrong organ); the incident is detected at any time after the start of the procedure.

- Includes wrong level spinal surgery and interventions that are considered surgical but may be done outside of a surgical environment e.g. wrong site block, biopsy, radiological procedures, cardiology procedures, drain insertion and line insertion.
- Excludes interventions where the wrong site is selected because of unknown/unexpected abnormalities in the patient’s anatomy. This should be documented in the patient’s notes.
- Excludes incidents where the wrong site surgery is due to incorrect laboratory reports or results

**Setting:** All patients receiving NHS funded care.

**Guidance:**
- ‘How to Guide to the five steps to safer surgery’, 2010, available at [http://www.nrli.nrls.npsa.nhs.uk/resources/?EntryId45=92901](http://www.nrli.nrls.npsa.nhs.uk/resources/?EntryId45=92901)

### 2. Wrong implant/prosthesis

Surgical placement of the wrong implant or prosthesis where the implant/prosthesis placed in
the patient is other than that specified in the surgical plan either prior to or during the procedure and the incident is detected at any time after the implant/prosthesis is placed in the patient.

- Excludes where the implant/prosthesis placed in the patient is intentionally different from the surgical plan, where this is based on clinical judgement at the time of the procedure
- Excludes where the implant/prosthesis placed in the patient is intentionally planned and placed but later found to be suboptimal.

**Setting:** All patients receiving NHS funded care.

**Guidance:**
- * How to Guide to the five steps to safer surgery, 2010, available at [http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92301](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92301)

### 3. Retained foreign object post-procedure

Retention of a foreign object in a patient after a surgical/invasive procedure.

‘Surgical/invasive procedure’ includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside of the surgical environment e.g. central line placement in ward areas

‘Foreign object’ includes any items that should be subject to a formal counting /checking process at the commencement of the procedure and a counting /checking process before the procedure is completed (such as swabs, needles, instruments and guidewires) **except where:**

- Items are inserted during the procedure but are intentionally retained after completion of the procedure, with removal planned for a later time or date
- Items are known to be missing prior to the completion of the procedure and may be within the patient (e.g. screw fragments, drill bits) but where further action to locate and/or retrieve would be impossible or be more damaging than retention
- Items were inserted at an earlier date or time and not removed as planned during a later surgical/invasive procedure

See the Appendix X on page X for examples of correct application of this never event definition.

**Settings:** All patients receiving NHS funded care.

**Guidance:**
- How to Guide to the five steps to safer surgery’, 2010, available at [http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901)
- Reducing the risk of retained throat packs after surgery, 2009, available at [http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59853](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59853)
- Reducing the risk of retained swabs after vaginal birth and perineal suturing, 2010, available at [http://www.nrls.npsa.nhs.uk/resources/?EntryId45=74113](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=74113)
- Reducing the risk of retained swabs after vaginal birth and perineal suturing, 2010, available at [http://www.nrls.npsa.nhs.uk/resources/?EntryId45=74113](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=74113)
- Risk of harm from retained guidewires following central venous access, 2011, available at [http://www.nrls.npsa.nhs.uk/resources/?entryid45=132829](http://www.nrls.npsa.nhs.uk/resources/?entryid45=132829)

**Consultation point:** The proposed never event includes retained vaginal swabs following home delivery when only one midwife is present. Do you consider the established guidance provides a very strong barrier to a lone practitioner inadvertently leaving a swab *in situ*?

**MEDICATION**

4. **Wrongly manufactured high-risk injectable medication**

A high-risk injectable medication is wrongly manufactured in a hospital pharmaceutical department with the intention of it being administered to a patient. This includes products manufactured aseptically on the ward in aseptic cabinets but does not include simple dilution in
a ward situation.

- High-risk injectable medicines are defined as those listed by the NHS Aseptic Pharmacy Services Group.
- High risk injectable medication is considered wrongly manufactured if manufacture was not compliant with the manufacturer’s Specification of Product Characteristics;

**Setting:** All patients receiving NHS funded care.

**Guidance:**

5. Maladministration of a potassium-containing solution

Maladministration of a potassium-containing solution. Maladministration refers to;

- selection of strong\(^2\) potassium solution instead of intended other medication,

**Setting:** All patients receiving NHS funded care.

**Guidance:**
- *Standard Operating Protocol fact sheet; Managing Concentrated Injectable Medicines*, part of the WHO High 5’s project, available at [https://www.high5s.org/bin/view/Main/WebHome](https://www.high5s.org/bin/view/Main/WebHome)

**Consultation point:** Earlier definitions of this Never Event also included ‘infusion at a greater rate than intended’. Do you consider any established guidance provides a very strong barrier to delivering an infusion at the wrong rate, and therefore justifies including this in the Never Event definition? If such guidance exists, is it feasible to have an unambiguous definition of what constitutes infusion at a rate greater than intended, given delivery at rates only slightly higher than intended are unlikely to present a significant risk to patients?

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\(^2\) ≥10% potassium w/v (e.g. ≥ 0.1g/ml potassium chloride, 1.3mmol/ml potassium chloride)
6. **Wrong route medication**

Wrong route administration of liquid medication or enteral feed

The patient receives one of the following:

- Intravenous chemotherapy that is correctly prescribed but administered via the intrathecal route
- Oral/enteral medication feed or flush administered by any parenteral route
- Intravenous administration of a medicine intended to be administered via the epidural route

**Setting:** All patients receiving NHS funded care.

**Guidance:**
- **Minimising Risks of Mismatching Spinal, Epidural and Regional Devices with Incompatible Connectors, 2011,** available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=132897
- **Safer spinal (intrathecal), epidural and regional devices,** 2011, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=94529
- **Patient safety alert on non-Luer spinal (intrathecal) devices for chemotherapy 2014,** available at http://www.england.nhs.uk/2014/02/20/psa-spinal-chemo/

7. **Maladministration of Insulin**

Maladministration of insulin by a health professional.

Maladministration in this instance refers to a tenfold or greater overdose of insulin administered to the patient:

- when a health professional(s) abbreviates the words ‘unit’ or ‘units’ when prescribing insulin in writing
- when a health care professional fails to use a specific insulin administration device e.g. an insulin syringe or insulin pen to draw up or administer insulin
### 8. Wrong frequency administration of methotrexate for non-cancer treatment

Supply or administration of methotrexate by any route to a patient for non-cancer treatment more frequently than the required once weekly treatment.

- Excludes cancer treatment with daily oral methotrexate
- Excludes where the error is intercepted before the patient is supplied with the medication.

**Setting:** All patients receiving NHS funded care.

**Guidance:**

**Consultation point:** Earlier definitions of this Never Event also included ‘prescription’. Do you consider any established system or guidance is available that provides a very strong barrier to wrong prescribing in all sectors?

### MENTAL HEALTH

### 9. Failure to install functional collapsible shower or curtain rails

Involves either;

- failure of collapsible curtain or shower rails to collapse when an inpatient suicide is attempted.
- failure to install collapsible rails and an inpatient suicide is attempted using these non-collapsible rails

**Setting:** All mental health inpatient premises.

**Guidance:**

GENERAL

10. Falls from unrestricted windows

A patient falling from an unrestricted window.

- Applies to windows “within reach” of patients. This means windows (including the window sill) that are within reach of someone standing at floor level and that can be exited/fallen from without needing to move furniture or use tools to assist in climbing out of the window.
- Includes windows located in facilities/areas where healthcare is provided and where patients can and do access.
- Includes where patients deliberately or accidentally fall from a window where a restrictor has been fitted but previously damaged or disabled, but does not include events where a patient deliberately disables a restrictor or breaks the window immediately before the fall.

Setting: All patients receiving NHS funded care

Guidance:

11. Chest or neck entrapment in bedrails

Entrapment of a patient’s chest or neck within bedrails, or between bedrails, bedframe or mattress, where the bedrail dimensions or the combined bedrail, bedframe and mattress dimensions do not comply with Medicines and Healthcare products Regulatory Agency (MHRA) guidance

Setting: All settings providing NHS funded healthcare, including NHS funded patients in care home settings, and equipment provided by the NHS for use in patients’ own homes.

Guidance:
- DB 2006(06) v 2.1 Safe use of bed rails, Dec 2013, available at
### 12. Transfusion or transplantation of ABO-incompatible blood components or organs

Inadvertent transfusion of ABO-incompatible blood components.

- Excludes where ABO-incompatible blood components are deliberately transfused with appropriate management.

Inadvertent ABO mismatched solid organ transplantation.

- Excluded are scenarios in which clinically appropriate ABO incompatible solid organs are transplanted deliberately
  - In this context, ‘incompatible’ antibodies must be clinically significant. If the recipient has donor specific anti-ABO antibodies and is therefore, likely to have an immune reaction to a specific ABO compatible organ then it would be a never event to transplant that organ inadvertently and without appropriate management.

**Setting:** All patients receiving NHS funded care.

**Guidance:**

### 13. Misplaced naso- or oro-gastric tubes

Misplacement and use of a naso- or oro-gastric tube in the pleura or respiratory tract where the misplacement of the tube is not detected prior to commencement of feeding, flush or medication administration.

**Setting:** All patients receiving NHS funded care.

**Guidance:**
**14. Scalding of patients**

Patient being scalded by water used for washing/bathing

- Excludes scalds from water being used for purposes other than washing/bathing (e.g. from kettles)

**Settings:** All patients receiving NHS funded care.

**Guidance:**